Psychiatric Bulletin (1993), **17**, 232–233

Forum

The Adventure of the Missing Triform

DREW RIDLEY-SIEGERT, Consultant Psychiatrist, Royal Hamadryad Hospital, Docks, Cardiff CF1 6UQ

With apologies to Sir Arthur Conan Doyle.

It was a day of quite intemperate heat as into our office in the Department of Applied Management Need burst an individual of some 40 years, perspiring as much, perhaps, from the heat and haste as the layers of clothing he affected. Beneath a pristine white coat he wore a pin-striped waistcoat and trousers, a starched shirt, striped tie and crimson kerchief fountaining from his breast pocket.

"Mr Holmes!" he cried. "I beseech you to help me."

"My dear Dr Moriarty. Pray sit down before you overheat yourself," replied Holmes.

"You know me?" the visitor gasped in surprise.

"No, but I am perfectly capable of reading your name badge, even at this distance".

"I see".

"Doctor, I am sure your patients will be needing your most urgent ministrations and, so as not to take up valuable time and cause them distress, I suggest you lay before me without delay the facts relating to your unscheduled visit to these quarters."

"Well, you see, Mr Holmes, that is just the problem," the distraught Doctor replied, leaping to his feet and commencing to pace, while his hands clenched so tortuously behind his back that I feared a most imminent dislocation. "I have been consultant psychiatrist nigh on ten years at the local mental hospital. Having returned just two days past from weekend conference in Southampton on Transference in Cost Improvement Programmes, I find I appear to have no patients."

"No patients?" I cried, also springing to my feet. "But what is a surgeon or physician without patients? Why, it would render our whole being meaningless and vacuous, as if the universe were ruled by chance or the random whims of some crude and witless gods!"

"Possibly, my dear Watson but we must let your colleague come to his conclusions in his own time and his own way. Pray, be seated good fellow."

"Thank you, Mr Holmes," muttered Moriarty, sinking into a chair and passing his hand over his face, as if by doing so he could clear away the veil of gloom that now descended upon him.

"I suppose," he continued, "that in fact my breach of contact with patients has not been as sudden as I may have led you to believe. When the Committee of Medical Manpower created the Training Grade Specialist, thereby liberating trainees of the need for any clinical supervision other than attendance at the weekly Quality in Self-Criticism Workshops, it became more cost effective to replace retiring consultants with self-managed teams of shift-workers. Two years ago, the European Nursing Board approved extending nursing roles to enable them to become Prescribing Nurse Practitioners. Then, while at the Symposium last weekend, the Clinical Management Board met in emergency session to deliberate on the competitive tenders for Neurosis, Day Care and Rehabilitation (including Counselling and Psychotherapies). Oh to be sure, the tender went in house; but to Margo's Hairdressing and Beauty Salon in the main concourse!"

At this, it seemed our visitor fell into a cataplexy and was unable to continue. Holmes rose to his feet and went to stand by the window. He paused a moment, then turned back to face the broken creature looking up at him in despair.

"Do you think you can help me, Mr Holmes?"

"Simplicity itself, my dear fellow. You see, it is not that you have lost your patients; rather, it is that you have not defined your function."

"But I am a Consultant Psychiatrist!"

"Not any more," replied Holmes. "Henceforth, you are Mental Health Facilitator."

"I do not understand," murmured the baffled Moriarty.

"It is elementary, my dear Doctor. In management, function follows form; or, in this case, triform. You see, you have manifestly failed to take heed of the development of extra-titular activity. Anyone and anything of importance in the new health service has three components to its nomenclature."

"And Consultant Psychiatrist has only two ?" The light was dawning in Moriarty's eyes.

"Precisely," replied Holmes. "Devise your triform and your function will surely follow."

Moriarty surged forward and grasped Holmes' hand between both his own.

"Thank you," he said, "Thank you!"
"And now" continued Holmes, "Might I suggest you hurry along to see Mr Trade in his office next door, for it is he whom you must persuade of your purpose."
"Les Trade? The Head Porter!" queried Moriarty.
"Not since The Triformation," returned Holmes, showing the contented consultant out. "He is now Chief Inspector Les Trade of the Continuous Improvement Directorate. Watson, be so kind as to pass me the audit figures. I have a need to play the fiddle."

Psychiatric Bulletin (1993), **17**, 233–234

The arrogance of insight?

RACHEL PERKINS, Consultant Clinical Psychologist, Springfield University Hospital; and PARIMALA MOODLEY, Senior Lecturer in Community Mental Health, Institute of Psychiatry and The Maudsley Hospital, Denmark Hill, London SE5 8AF

People's beliefs about illness, distress and disability profoundly influence their experience of, and responses to, such problems. Medical anthropologists have long recognised the importance of explanatory models of physical illness and the impact of these on the provision and use of health services. Similarly, psychological models of physical illness and related behaviour stress the importance of the ways in which people conceptualise or understand their difficulties. These are central in determining emotional responses to illness, help-seeking and illness-related behaviours, attitudes towards and compliance with treatment. Eisenbruch (1990) argues that, "the culturally constructed ideas held by the patient about the cause and nature of disease" are as important in relation to mental distress and disturbance. Help-seeking behaviour, attitudes towards and compliance with treatment are of central concern in psychiatry and all of these are influenced by people's understandings of their difficulties. Yet relatively little attention has been paid to the ways in which people conceptualise their mental distress.

Typically, mental health professionals make use of the concept of insight. A person's understanding of their problem is seen as symptomatic of their condition. Despite suggestions that this concept of insight is of limited value, it is still very much alive in current clinical practice.

David (1990) has argued that the concept of insight should be elaborated and extended. In particular, he argues that insight should not be seen as an all-or-nothing phenomenon and that it comprises three distinct, but overlapping, dimensions: the recognition that one has a mental illness, compliance with treatment, and the ability to relabel unusual mental events as pathological. Such a 'reformation' does indeed make more specific the 'correct' attitude to which Aubrey Lewis referred in defining insight as "a correct attitude to morbid change in oneself" (Lewis, 1934), and could undoubtedly lead to a more uniform and less confused use of the concept. However, it does make more specific the value judgements and framework within which the concept gains its meaning.

In David's (1990) formulation insight means not only agreeing with the doctor that one is mentally ill, but agreeing with the remediation for that illness (as defined within a psychiatric framework), and reconstructing one's experience with the terms and concepts of Western psychiatry, rather than one's karma or bodily imbalance or disharmony. Several studies have shown that around half of those people admitted to psychiatric hospital lack insight in that they do not consider themselves to have a mental illness (see Moodley & Perkins, 1991a & b). Clearly, a significant proportion of newly admitted psychiatric patients do not concur with a psychiatric view of their difficulties.

Insight is an extremely crude concept and offers an extremely limited index of the way a person understands their distress and disturbance. David's (1990) elaboration does not change this. There are many different frameworks within which people understand their difficulties (Eisenbuch, 1990; Moodley & Perkins, 1991a & b). Some adopt religious explanations of their world, while others use models couched in physical processes, or social/interpersonal explanatory frameworks. It is not the case that a person uses a single explanatory framework. As in other areas of human experience, a single individual may simultaneously hold a range of different and sometimes mutually incompatible